STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155377	B. WING		01/08/2013
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
SEYMOL	JR CROSSING			JACKSON PARK DR DUR, IN 47274	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000					
	Revisit (PSR) Complaint INC Complaint INC 11-19-2012.  Complaint INC Corrected.  Complaint INC Corrected.  Complaint INC Survey dates: Facility number Provider number AIM number 1  Survey team: Penny Marlatt Census bed ty SNF/NF: 77 Total: 77  Census payor Medicare: 8 Medicaid: 65 Other: 4 Total: 77  Sample: 3	00119399 completed on 00118544 Not 00119399 Corrected. January 7 and 8, 2013 er: 000272 per: 155377 00274710 , RN	F0000	The creation and submission this Plan of Correction does no constitute an admission by the provider of any conclusion seforth in the statement of deficiencies, or of any violation of the statement of deficiencies, or of any violation of the statement of deficiencies, or of any violation of the statement of the statement of deficiencies, or of any violation of the statement of t	iot is t in

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

000272

PRINTED: 01/28/2013 FORM APPROVED OMB NO. 0938-0391

	of CORRECTION IDENTIFICATION 155377	N NUMBER:	X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPI 01/08	LETED
	ROVIDER OR SUPPLIER  JR CROSSING		707 S J	DDRESS, CITY, STATE, ZIP COD ACKSON PARK DR UR, IN 47274	E	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D (EACH DEFICIENCY MUST BE PRI REGULATORY OR LSC IDENTIFYIN	ECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	findings cited in accordance IAC 16.2.	ce with 410				
	Quality review 1/14/13 by Williams, RN	Suzanne				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TEG312

Facility ID: 000272

If continuation sheet

Page 2 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155377	B. WIN			01/08/	2013
			b. Wilv	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	-			ACKSON PARK DR		
SEYMOL	IR CROSSING				OUR, IN 47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0282 SS=D	483.20(k)(3)(ii) SERVICES BY Q CARE PLAN The services prove facility must be presens in accord written plan of car Based on observecord review, fensure physicial medication were the incorrect do for diabetes gived days, for 1 of 3 physician order administration in (Resident #F)  Findings include The clinical recovers reviewed of the diagnoses limited to diabete neuropathy, higosteoarthritis and disease. Her and Data Set assess 12-21-12, indiccognitively intaken.	UALIFIED PERSONS/PER  vided or arranged by the evoided by qualified flance with each resident's re. rvation, interview and the facility failed to an orders for re followed, resulting in esage of a medication ven to a resident for 4 residents reviewed for rs for medication in a sample of 3.  e:  cord of Resident #F on 1-7-13 at 2:00 p.m. included, but were not etes, peripheral gh blood pressure, and degenerative disc admission Minimum esment, dated ated she was	F02	TAG	F 282 Services Provided Mee Professional Standards It is to policy of the facility to provide services utilizing qualified persons in accordance with earesidents plan of care. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Upon finding medication error on 1/5/13 resident F received head to to assessment with no new findir vital signs were taken and wer within normal limits. Physiciar and resident responsible party were re-notified during survey a new order was obtained from physician. Resident F received head to be affected by the same deficient practice and what corrective action will be taken.  Residents who reside in this facility have the potential to be affected by the alleged	t he engs; een and ne ves w nts	DATE  01/23/2013
	of Nursing Service copy of a documedication error	vice (DNS) provided a ment indicating a or had been identified or Resident #F on			deficient practice. • Medicatic administration record rewrites from December 2012 going int January 2013 will be audited to ensure there are no further	:0	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TEG312

Facility ID: 000272

If continuation sheet

Page 3 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPL	ETED
		155377		LDING		01/08/	2013
			B. WIN		ADDRESS CITY STATE ZIR CODE		
NAME OF F	PROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP CODE		
OEVMOL	ID ODGGGING				IACKSON PARK DR		
SEYMOU	JR CROSSING			SEYIVIC	DUR, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1-5-13.				transcription errors. Any error	S	
					found will be addressed and		
	Review of the	nursing progress notes,			corrected per facility policy.		
	dated 1-5-13 at 2:50 p.m., indicated,				Licensed Nurses including Nu		
		-			Managers will be inserviced o		
		edication for diabetes] 5			Medication Order Change Pol and by the Director of Nursing		
		received BID [twice			Services Consultant on 1/23/1		
	daily.] Medica				What measures will be put in		
	immediately. I	MD notified, DNS and			place or what systemic		
	resident aware	e. Resident is own POA			changes you will make to		
	Ipower of attor	ney]. No new orders			ensure that the deficient		
	l	. Fingersticks [blood			practice does not recur?		
	•	within normal range.			Nurses Managers will be		
	_	_			completing monthly medication	n	
		sessment performed			administration record rewrites		
		ndings. Vital signs			will be assigned to each other	S	
	taken upon fin	ding Tradjenta 5 mg			rewrites as a double check.		
	given BID. All	vital signs WNL [within			Charge nurses will no longer		
	normal levels].	"			completing rewrites. This sys		
	•				will be reviewed with DNS and		
	Review of the	physician's admission			nurse managers by Director o		
		12-14-12, indicated the			Nursing Consultant on 1/23/13	3. ·	
					The director of nursing is responsible for compliance		
		receive Tradjenta 5			related to medication order		
	mg once daily	by mouth.			changes and medication error		
					procedures. Non-compliance		
	Review of the	December 2012			with medication order change		
	Medication Ad	ministration Record			and medication error procedu		
	(MAR) indicate	ed this medication was			may result in further education		
		s ordered by the			and/or disciplinary action up to		
		•			termination. Licensed Nurse	es	
		an administration time			including Nurse Managers wil		
		aily and administered			inserviced on Medication Orde	er	
		through 12-31-12 at			Change Policy and by the		
	this time by fac	cility staff.			Director of Nursing Services		
					Consultant on 1/23/13. How v	VIII	
	Review of the	January 2013			the corrective action(s) be		
		orders indicated to			monitored to ensure the		
	•	djenta 5 mg once daily			deficient practice will not rec	cur,	
	l administer Ha	ajenia o my once dally			i.e., what quality assurance		I

PRINTED: 01/28/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155377	B. WIN	1G		01/08/2013
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
					ACKSON PARK DR	
SEYMOU	JR CROSSING			SEYMO	DUR, IN 47274	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	,	he section which			program will be put into plac	
		me in which the			<ul> <li>Nurse Managers will audit n orders for accuracy and</li> </ul>	ew
		o be administered, the			completeness daily times four	
		ration time of "4pm"			weeks then Monday through	
	was marked ou	ut with a line and the			Friday thereafter. · A Medicat	
	time of "8am" \	was written in above			Errors CQI tool will be utilized	by
	the typed time.	. Review of the			the director of nursing and/or	oko
	January 2013	MAR on 1-8-13 at 8:50			designee twice weekly x 4 weekly x 2 monthly x 2 months and quart	
	a.m. indicated	Tradjenta 5 mg was			X 1 for at least 6 months. · A	,
	administered to	wice daily on 1-1-13,			Medical Records CQI tool will	be
	1-2-13, 1-3-13	and 1-4-13. The			utilized by the director of nursi	•
	January 2013	MAR indicated a written			and/or designee twice weekly	
	administration	time of 8:00 a.m. and a			weeks, monthly x 2 months ar quarterly X 1 for at least 6	a
	second time th	at was unreadable as			months. Audit tools will be	
	the second tim	e frame was marked			submitted to the CQI committee	e
	out.				and if threshold of 95% is not	
					achieved ,action plans will be	
	On 1-8-13 at 1	1:40 a.m., an			developed as needed.	
		a count of the current				
	supply of Resid	dent F's Tradjenta 5 mg				
		d with the Corporate				
		DNS. A 30-day supply				
	of this medicat	• • • •				
		5 tablets remaining.				
		icate 4 additional				
		dministered to the				
		n would be consistent				
	′	use twice daily, as				
	,	e ordered once daily.				
		, ordered office dally.				
	In interview wit	th the DNS on 1-8-13 at				
	11:44 a.m., sh					
	· · · · · · · · · · · · · · · · · · ·	or was related to the				
		rk is a multi-part				
	l aocument. Sh	e indicated the nurse				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TEG312

Facility ID: 000272

If continuation sheet

Page 5 of 12

PRINTED: 01/28/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155377	B. WIN	G		01/08/	2013
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					ACKSON PARK DR		
SEYMOL	JR CROSSING			SEYMO	DUR, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		the January 2013					
	•	orders did mark out the					
	•	and replaced it with					
	the 8:00 a.m. a	dministration time.					
	She indicated t						
	•	ment, this information					
		y transfer to the actual					
	MAR for Resid	ent #F as this is the					
	last portion of t	he multi-part					
	document.						
	The DNS provi	ded a copy of a policy					
	entitled, "Medio	cation Order Changes,"					
	with a revision	date of 7-2011. This					
	policy indicated	d, "Purpose: To					
	establish a uni	form procedure to be					
	followed to ens	sure physician's					
	medication ord	er changes are carried					
	through. To er	nsure residents receive					
	medications as	ordered by the					
	physicianWh	en the directions of a					
		rently in use have been					
		urse willIf only part of					
		anging, the entire					
		must be discontinued					
	•	new order must be					
		diately enter the new					
		er on the resident's					
		atment Administration					
	_	Draw a line through					
	-	being change [sic] and					
		d order changed,' the					
	date, time, and	_					
		ls. Do not alter existing					
	order."	.cc not allor omoting					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TEG312

Facility ID: 000272

If continuation sheet Page 6 of 12

PRINTED: 01/28/2013 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number:  155377	A. BUILDING  B. WING	00	COMPL 01/08/	ETED
	PROVIDER OR SUPPLIER  JR CROSSING	707 S J	ADDRESS, CITY, STATE, ZIP CODI JACKSON PARK DR DUR, IN 47274	E	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	This federal tag was cited on 11-19-12. The facility failed to implement a systemic plan of correction to prevent recurrence.  This federal tag relates to complaint IN00118544.  3.1-35(g)(2)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TEG312

Facility ID: 000272

If continuation sheet

Page 7 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE S			
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER: 155377	A. BUII	DING	00	COMPL 01/08/	
		199977	B. WIN			01/06/	2013
NAME OF PI	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR		
SEYMOU	R CROSSING				OUR, IN 47274		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
F0514 SS=D	483.75(I)(1) RES RECORDS-COM SSIBLE The facility must reach resident in a professional standare complete; accreadily accessible organized.  The clinical record information to ide of the resident's acare and services any preadmission the State; and probased on obserecord review, ensure correct administration of a diabetic medication for residents review medication administration (Resident #F)  Findings includ The clinical recovery reviewed of the diagnoses limited to, diabet neuropathy, high	maintain clinical records on accordance with accepted dards and practices that curately documented; e; and systematically  d must contain sufficient accepted dards and practices that curately documented; e; and systematically  d must contain sufficient accord accepted days, for 1 of 3 accepted days, for 1 of 3 accepted days, for 2 of 3 accepted days, for 1 of 3 accepted days, for	F05		F 514 Resident Records- Complete/Accurate/Accessib It is the policy of the facility to maintain clinical records on ea resident in accordance with accepted professional standar and practices that are complet accurately documented; readil accessible; and systematically organized. What corrective action(s) will be accomplishe for those residents found to have been affected by the deficient practice? Upon finding medication error on 1/5 resident F received head to to assessment with no new findir vital signs were taken and wer within normal limits. Physiciar and resident responsible party were re-notified during survey a new order was obtained fron physician. Resident F receive medications per MD order. Ho will you identify other resident	ach ds ds; ee; yy  add  5/13 ee ngs; ee n and n ves	01/23/2013

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: TEG312 Facility ID: 000272 If continuation sheet Page 8 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE SUR	VEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DINC	00	COMPLETE	D
		155377	A. BUIL B. WING			01/08/201	3
			B. WINC		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIE	R			IACKSON PARK DR		
SEVMOL	JR CROSSING						
SETIVIOL	JR CROSSING			SETIVIC	DUR, IN 47274		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE CC	OMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	disease. Her a	admission Minimum			having the potential to be		
	Data Set asse	ssment, dated			affected by the same deficien		
	12-21-12, indicated she was				practice and what corrective		
	cognitively inta				action will be taken.		
	cogrimatory into				Residents who reside in	_	
	On 1 7 12 ct 1	1:02 a m the Director			this facility have the potential the affected by the alleged	.O	
		1:03 a.m., the Director			be affected by the alleged deficient practice. Medication	)n	
		vice (DNS) provided a			administration record rewrites		
		iment indicating a			from December 2012 going in		
	medication err	or had been identified			January 2013 will be audited t		
	by the facility f	or Resident #F on			ensure there are no further		
	1-5-13.				transcription errors. Any error	s	
					found will be addressed and		
	Review of the	nursing progress notes,			corrected per facility policy.		
		it 2:50 p.m., indicated,			Licensed Nurses including Nu		
		-			Managers will be inserviced of		
	1	ig [milligram] received			Medication Order Change Pol		
	_	y.] Medication			and by the Director of Nursing		
	corrected imm	ediately. MD notified,			Services Consultant on 1/23/1	-	
	DNS and resid	lent aware. Resident is			What measures will be put in	110	
	own POA [pow	ver of attorney]. No			place or what systemic changes you will make to		
	new orders giv				ensure that the deficient		
		lood sugar results]			practice does not recur?		
		range. Head to toe			Nurses Managers will be		
		•			completing monthly medicatio	n l	
	· ·	erformed with no new			administration record rewrites	l l	
	5	signs taken upon			will be assigned to each other		
	finding Tradjer	nta 5 mg given BID. All			rewrites as a double check.		
	vital signs WN	L [within normal			Charge nurses will no longer b		
	levels]."				completing rewrites. This syst	l l	
	_				will be reviewed with DNS and	I	
	Review of the	physician's admission			nurse managers by Director o		
	Review of the physician's admission				Nursing Consultant on 1/23/13	5. ·	
orders, dated 12-14-12, indicated the				The director of nursing is			
		o receive Tradjenta 5			responsible for compliance related to medication order		
	mg once daily by mouth.				changes and medication error		
					procedures. · Non-compliance		
	Review of the	December 2012			with medication order changes		
	Medication Ad	ministration Record			and medication error procedu		

PRINTED: 01/28/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION		A. BUI	LDING	00	COMPL	
		155377	B. WIN			01/08/	2013
NAME OF 1	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
05)/140	ID 00000110				ACKSON PARK DR		
SEYMOU	JR CROSSING			SEYMC	DUR, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	, ,	ed this medication was			may result in further education		
		s ordered by the			and/or disciplinary action up to termination. Licensed Nurse		
	physician with	an administration time			including Nurse Managers will		
	of 8:00 a.m. da	aily and administered			inserviced on Medication Orde		
	from 12-15-12	through 12-31-12 at			Change Policy and by the		
	this time by fac	cility staff.			Director of Nursing Services		
					Consultant on 1/23/13. How w	/ill	
	Review of the	January 2013			the corrective action(s) be		
		orders indicated to			monitored to ensure the deficient practice will not rec	· iir	
	· ·	djenta 5 mg once daily			i.e., what quality assurance	ui,	
		he section which			program will be put into place	e?	
	1	me in which the			Nurse Managers will audit n		
		o be administered, the			orders for accuracy and		
		ration time of "4pm"			completeness daily times four		
	1 .	ut with a line and the			weeks then Monday through	:	
		was written in above			Friday thereafter. A Medicat Errors CQI tool will be utilized		
		Review of the			the director of nursing and/or	Бу	
		MAR on 1-8-13 at 8:50			designee twice weekly x 4 wee	eks,	
	1	Tradjenta 5 mg was			monthly x 2 months and quart	erly	
		wice daily on 1-1-13,			X 1 for at least 6 months. · A		
					Medical Records CQI tool will utilized by the director of nursi		
		and 1-4-13. The			and/or designee twice weekly	-	
		MAR indicated a written			weeks, monthly x 2 months ar		
		time of 8:00 a.m. and a			quarterly X 1 for at least 6		
		at was unreadable as			months. · Audit tools will be		
		e frame was marked			submitted to the CQI committee		
	out.				and if threshold of 95% is not achieved, action plans will be		
					developed as needed.		
	On 1-8-13 at 1	•			acvereped de necaca.		
		a count of the current					
		dent F's Tradjenta 5 mg					
		d with the Corporate					
	Nurse and the	DNS. A 30-day supply					
	of this medicat	ion was dated					
	12-18-12 with	5 tablets remaining.					
	This would ind	icate 4 additional					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TEG312

Facility ID: 000272

If continuation sheet

Page 10 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155377	B. WIN	G		01/08/	2013
NAME OF I	DROVIDED OD GUDDI IEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF F	PROVIDER OR SUPPLIEF	C		707 S J	ACKSON PARK DR		
SEYMOL	JR CROSSING			SEYMO	DUR, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		dministered to the					
	·	n would be consistent					
	with 4 days of use twice daily, as opposed to the ordered once daily.  In interview with the DNS on 1-8-13 at 11:44 a.m., she indicated the						
		or was related to the					
	MAR paperwo	rk is a multi-part					
	document. Sh	e indicated the nurse					
	who reviewed	the January 2013					
	recapitulation of	orders did mark out the					
	4:00 p.m. dose	and replaced it with					
	the 8:00 a.m. a	administration time.					
	She indicated t	that due to the					
	multi-part docu	ıment, this information					
	did not properly	y transfer to the actual					
	MAR for Resid	ent #F as this is the					
	last portion of t	the multi-part					
	document.	·					
		ided a copy of a policy					
	· ·	cation Order Changes,"					
		date of 7-2011. This					
	l · ·	d, "Purpose: To					
	establish a uni	form procedure to be					
	followed to ens	sure physician's					
	medication ord	ler changes are carried					
	through. To er	nsure residents receive					
	medications as	ordered by the					
	physicianWh	en the directions of a					
	medication cur	rently in use have been					
	changed, the n	nurse willIf only part of					
	the order is cha	anging, the entire					
	previous order	must be discontinued					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TEG312

Facility ID: 000272

If continuation sheet Page 11 of 12

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155377	B. WIN			01/08/	/2013
		1	D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		l	ACKSON PARK DR		
SEYMOL	JR CROSSING				DUR, IN 47274		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	and the entire	new order must be					
	writtenImme	diately enter the new					
	medication ord	der on the resident's					
	MAR/TAR [Tre	eatment Administration					
		Draw a line through					
	_	being change [sic] and					
		d order changed,' the					
	date, time, and	•					
		lls. Do not alter existing					
	order."	iis. Do not alter existing					
	order.						
	This fodoval to	a was sited on					
		g was cited on					
		e facility failed to					
		ystemic plan of					
	correction to p	revent recurrence.					
		g relates to complaint					
	IN00118544.						
	3.1-50(a)(1)						
	3.1-50(a)(2)						
F9999							
			F99	99	This dose not require a plan o correction.	f	01/23/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TEG312

Facility ID: 000272

If continuation sheet

Page 12 of 12